

WRITTEN SECTION REPORTS

CLINICAL POLICY AND PROGRAMS REPORT

(REPORT PERIOD APRIL 2, 2015 THROUGH SEPTEMBER 1, 2015)

1. POLICIES PRESENTED TO THE N.C. PHYSICIAN ADVISORY GROUP (PAG)

The N.C. Physician Advisory Group met on 5/28/15, 8/27/15

The Pharmacy & Therapeutic Committee met on Dates 6/9/15, 8/11/15.

Recommended Policies

- Preferred Drug List (PDL) (5/28/15)
- 3D, Hospice Services (5/28/15)
- PA Criteria Hematinics (8/27/15)
- PA Criteria Systemic Immunomodulators (8/27/15)
- PA Criteria Narcotic Analgesics (8/27/15)
- PA Criteria PCSK9 Inhibitors (8/27/15)

PAG Administrative Notification

- 5A, Durable Medical Equipment (8/27/15)

PAG Consult

- None

2. POLICIES POSTED FOR PUBLIC COMMENT

- 1E-5, Obstetrics
- 3L, Personal Care Services
- 1A-6, Invasive Electrical Bone Growth Stimulation
- 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- 10D, Respiratory Therapy Services Independent Practitioner Providers
- 3D, Hospice Services
- Preferred Drug List (PDL)
- 5A, Durable Medical Equipment and Supplies

3. POLICIES POSTED FOR ADDITIONAL PUBLIC COMMENT

- 8A-1, Assertive Community Support Team (ACT)
- 8A-2, Facility-Based Crisis Service

4. AMENDED OR NEW POLICIES POSTED TO DMA WEBSITE

- 1E-7, Family Planning Services (5/1/15)
- 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 (4/1/15)
- 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older (2/2/15)
- 12A, Case Management Services for Adults and Children at Risk for Abuse, Neglect, or Exploitation (Date of Termination 6/30/14)
- 1N-2, Allergy Immunotherapy (5/3/15)
- 1A-40, Fecal Microbiota Transplantation (6/1/15)
- 3L, State Plan Personal Care Services (PCS) (6/10/15)
- 10B, Independent Practitioners (IP) (7/1/15)
- 10C, Local Education Agencies (LEAs) (7/1/15)
- 8A, Enhanced Mental Health and Substance Abuse Services (8/1/15)
- 8A-1, Assertive Community Treatment (ACT) Program (8/1/15)
- 1A-6, Invasive Electrical Bone Growth Stimulation (8/1/15)

BEHAVIORAL HEALTH CLINICAL POLICY REPORT

(THE FOLLOWING BEHAVIORAL HEALTH POLICIES ARE IN THE PROCESS OF BEING PROMULGATED OR AMENDED.)

1. 8A-1 ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM

This policy was fully promulgated with an effective date of August 1, 2015. This service definition was taken out of CCP 8A, Enhanced Mental Health and Substance Abuse Services, and was made a standalone policy, CCP 8A-1.

2. 8A-2 FACILITY BASED CRISIS FOR CHILDREN AND ADOLESCENTS (FBC-C)

FBC-C was posted for internal DMA comment, presented to PAG in January, posted for 45 day comment in April and is currently posted for another 15 day external posting. The additional 15 day posting will close on September 11, 2015. Fiscal note is pending with minor budgetary impact since this is a less expensive alternative to a higher, more costly level of care.

3. INTENSIVE IN-HOME (IIH)

Policy was revised to reflect legislative mandate to increase family to team ratio to 1:12 from 1:8. Policy was presented at PAG, posted for 45 external review, and SPA was updated to reflect the ratio change and fiscal impact. Approval from CMS regarding the rate change is still pending.

4. 8C OUTPATIENT BEHAVIORAL HEALTH SERVICES PROVIDED BY DIRECT ENROLLED PROVIDERS

This policy was posted for internal DMA comment, presented to PAG in March, and posted for 45 day comment. The fiscal note was completed; no impact noted. The policy changes have all been approved and this policy is scheduled to be posted with an effective date of October 1, 2015.

5. BEHAVIORAL HEALTH POLICY IN CONJUNCTION WITH OUR MEDICAL SERVICES, IS WORKING TO DEVELOP A BUPRENORPHINE POLICY TO PROVIDE PROVIDERS AND PHYSICIANS PRESCRIBING AND TREATMENT GUIDELINES.

6. ADDITIONAL BEHAVIORAL HEALTH UPDATES:

- Due to a legislative request, DMA is exploring the options for a 1915(c) waiver for children who are seriously and emotionally disturbed.
- Our LME-MCOs have the authority to develop and implement alternative service definitions to provide additional services for which they have identified as a need in their catchment area. DMA has approved 5 alternative service definitions.
- Behavioral health staff have worked diligently with CSC and DMA policy development staff to ensure a smooth transition from ICD-9 to ICD-10. Providers are encouraged to utilize the crosswalk located in the DSM 5.
- DMA and the Division of Mental Health, Developmental Disability, and Substance Abuse Services are working collaboratively to develop a fidelity based Supported Employment policy. This policy will be based off of the Individual Placement and Support model; designed to assist people with mental illness obtain and maintain employment.

BEHAVIORAL HEALTH IDD SECTION UPDATES:

1. Treatment for Autism Spectrum Disorder:

The Centers for Medicare and Medicaid Services have issued guidance on EPSDT coverage of Autism Spectrum Disorder. It is their expectation that States cover a continuum of services for these individuals. To that end, the State is exploring its options to provide additional services to this population with assistance from Mercer and stakeholder engagement.

2. TBI Waiver:

Session Law 2014-100, Section 12I.2 SECTION 12H.6 instructed the Department of Health and Human Services, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in conjunction with the North Carolina Advisory Council, to design and draft a 1915(c) waiver to add a new service package for Medicaid beneficiaries with traumatic brain injury (TBI). At this time, there has not been an allocation to fund the Traumatic Brain Injury Medicaid Waiver though both the Senate and the House have included it in their proposed budgets.

3. Innovations Waiver:

A technical amendment to the Innovations waiver to implement resource allocation and add flexibility to service definitions has been developed. It was posted for public comment in July 2015 and it has been updated to reflect changes made as a result of stakeholder feedback. The amendment will be submitted in September 2015.

4. Home and Community Based Services Rule:

The State's HCBS transition plan passed the initial phase of CMS approval. CMS requested additional information on the State's plan, which has been submitted. The State is scheduled to have a call with CMS in late September to discuss any outstanding concerns. The provider self-assessment was launched on 7/15/15 and will end on 9/15/15. Additional information on the HCBS Rule can be found at <http://www.ncdhhs.gov/hcbs/index.html>.

PROGRAM INTEGRITY REPORT

PAYMENT ERROR RATE MEASUREMENT (PERM)

On a three year cycle the Centers for Medicare and Medicaid Services (CMS), through the Payment Error Rate Measurement (PERM) program, measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP) and produces error rates for each program. To date the error rates have been based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. CMS considers the error rate a measurement of payments made to the state that did not meet statutory, regulatory or administrative requirements.

On July 29, 2015 the Department presented to CMS via a live webinar the 2013 PERM Corrective Action Plan including the actions taken to date to correct the errors identified in the 2013 PERM cycle. CMS was complimentary of the professionalism of the presentation as well as the proactive approach the Department has taken to correct the identified errors.

On August 27, 2015 CMS held a kick-off conference for the 2016 PERM cycle which will encompass a review of FFS and managed care claims for Federal Fiscal Year 2016. CMS does not plan to include an eligibility component during the 2016 cycle as they have implemented Eligibility Review Pilots for the FFY's 2014-2016.

MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)

On August 15, 2013 states were directed by CMS to implement Medicaid and Children's Health Insurance Program (CHIP) Eligibility Review Pilots in place of the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) eligibility reviews for fiscal years (FY) 2014 - 2016. States are conducting four streamlined pilot measurements over the three year period; pilots are based on how eligibility for applicants to the Medicaid and CHIP programs is determined under the Affordable Care Act (ACA). The Medicaid and CHIP Eligibility Review Pilots provide a testing ground for various approaches and methodologies for determining Medicaid and CHIP eligibility. Pilot results are expected to assist CMS with designing the anticipated 2017 rulemaking changes in the MEQC program.

RECIPIENT AND PROVIDER SERVICES REPORT

INCREASED ENROLLMENT OF BENEFICIARIES TO A PRIMARY CARE PROVIDER (PCP)

The N.C. Division of Medical Assistance (DMA) will be auto-assigning an eligible population of Medicaid and NC Health Choice (NCHC) beneficiaries with a Community Care of N.C. (CCNC) primary care provider (PCP), also referred to as a health home. It is anticipated that this initiative will begin September 2015.

CCNC is an enhanced primary care case management program which provides patient-centered, community-based, and evidence-based health care. Its goals are to improve quality and access to care, support appropriate utilization of services, and promote cost-effectiveness through care coordination within health homes.

Using the NCTracks Medicaid Management Information System (MMIS), targeted Medicaid and NCHC beneficiaries will be linked to a CCNC PCP in their county of residence. Medicaid caseworkers in the county department of social services offices will answer beneficiary questions about assigned CCNC providers.

1099 REPORTING/PAY-TO ADDRESS ON PROVIDER RECORD

Over the past two years, hundreds of 1099s have been returned to NCTracks due to incorrect mailing addresses. The designation of a 1099 Reporting Address on the provider record will help providers know which address is used for 1099 reporting – and to change it, if needed – to increase the success of first-time mailings to providers. As part of this change, all NPIs with the same Taxpayer Identification Number (TIN) were given the same 1099 Reporting/Pay-To Address on their provider records. If there was more than one existing Pay-To Address among the NPIs associated with the same TIN, the system used the most recent record's Pay-To Address and copied it to all records with the same TIN.

Providers are encouraged to verify the 1099 Reporting/Pay-To Address on their provider record. If the 1099 Reporting/Pay-To Address is not correct, submit a Manage Change Request (MCR) with the correct 1099 Reporting/Pay-To Address. Organization Name should be the legal name for the TIN. Providers also have the opportunity to add/update their Doing Business as (DBA) Name. Many providers previously put their DBA Name in the Organization Name field.

#